PI C	evised 3 LAN ST Client lame:		N END DATE: MPI/Client#:	12345	Program Assignment:	Page 1 CSP Team	
Re	• ' ') for Recovery Plan completion: I Plan	☐ 90 da	ay review and Update	⊠ G	oal/Objective attainment or change	
		on above if necessary: w eligible for enhanced services with	the agency, through	the Behavioral Health	Home Initiative.		
C	Goal #1: (I	Long Term, in person's own words):					
I	want to	b be able to manage my medicati	ons on my own and	I not have to meet wit	h the nurse every r	norning at my house.	
Client Strengths & Supports, including Natural Community Supports: Strong family support; increasing recognition that meds Barriers/ skills development needed, i.e., what specific /needs from assessment(s) will be addressed to achieve this goal						, what specific /needs from assessment(s) will be addressed	
h	elp man	age diabetes; consistent use of medicati	ons in past 6 months wh		Cognitive symptoms lead to forgetfulness in taking meds; concerns re: side effects may		
delivered by staff nurse and prompted; desire to learn and be more independent with med self-administration				contribute to inconsistent use of medications. Mr. Jones would benefit from skills training around reminder techniques for taking medications.			
Goal 1 Objectives: (a, b, c, etc.) Using action words, describe the specific changes expected in measurable and behavioral terms, and include target date. Obj. a Objectives: (a, b, c, etc.) Using action words, describe the specific changes expected in measurable and behavioral terms, and include target date. a) Within 90 days, Mr. Jones will demonstrate ability to accurately self-administer his diabetes medication for 5 consecutive days as evidenced by nursing services report and blood sugar levels.							

Interventions/Action Steps Include detailed descriptions of rehabilitation interventions to be provided: 1:1 prompting, cuing, coaching, demonstrating, step by step written and/or verbal directions, visual and verbal directions.	Responsible Person, with credentials if applicable	Type of service/ Program TCM/CSP/RP/ Med Man/ Nat Support	Frequency: How Often	Est. # of Minutes for each Intervention	Duration/ For How long
1.a.1 Medication education to teach Mr. Jones to identify dosages/pills, and to better understand the side effects of the medications and things that may reduce side effects. (BHH SERVICE?)		CSP	1xweek	30 mins	3 mos.
1.a.2 Demonstration of self administration, identifying barriers to consistent self-administration, and for strategies for remembering, including reminder phone calls (BHH SERVICE?)		CSP	1XWeek	30 mins	3 mos.
1.a.3 Coordination with visiting nursing staff to ensure continued visiting nurse visits and to collaborate around supporting Mr. Jones pursuing med self-administration. (BHH SERVICE?)		TCM	1xMonth	30 mins	3 mos.
1.a.4 Meet with Rick to monitor Rick's follow through with plan of care and to reassess goals and objectives related to medication self-administration (BHH SERVICE?)		TCM	1x2 weeks	45 mins	3 mos.

Revised 3/9/15 PLAN START DATE: Client

PLAN END DATE:

Page 2

Name:

Rick Jones

MPI/Client#: 12345 **Program Assignment: CSP Team**

ANSWER KEY:

Goal 1: Interventions

	BHH Service	Coding
1.a.1	Health Promotion	H2027 (Psycho-Ed Face to Face)
1.a.2	Patient and Family Support	T1016 or T116C/T1016/PH, depending on task. (Case Management face to face or case management by phone)
1.a.3	Care Coordination	TCM03/2023T/CL (TCM with collateral)
1.a.4	Care Management	TCM01/2023T (TCM with client face to face)

Revised 3/9/15 PLAN START DATE: PLAN END Client Rick Jones Name:	DATE: MPI/Client#: 1234	5	Program Assignment:	CSP Team	Page 3
Reason(s) for Recovery Plan completion: Initial Plan	☐ 90 day rev	view and Update	⊠ Go	oal/Objective attainr	ment or change
Comments on above if necessary: Rick is now eligible for enhanced services with the a	gency, through the E	Behavioral Health	Home Initiative.		
Goal #2: (Long Term, in person's own words):	:				
I want to find a primary care doctor and mainta	ıın regular appointi	ments to better c	ontrol my blood sug	gar.	
Client Strengths & Supports, including Natural Community Strong family support; increasing recognition that control	ling blood sugar will	to achieve this	oal	•	rom assessment(s) will be addressed
improve quality of life; desire to be independent in sched doctor's appts	uling and keeping		duling and keeping app		with finding a primary care doctor, are coordination, referral, and patient
Goal 2 Obj. a Objectives: (a, b, c, etc.) Using action words change/readiness in developing objective ar a) Within 60 days, Mr. Jones will have	nd setting target date.	•		·	

Interventions/Action Steps Include detailed descriptions of rehabilitation interventions to be provided: 1:1 prompting, cuing, coaching, demonstrating, step by step written and/or verbal directions, visual and verbal directions.	Responsible Person, with credentials if applicable	Type of service/ Program TCM/CSP/RP/ Med Man/ Nat Support	Frequency: How Often	Est. # of Minutes for each Intervention	Duration/ For How long
2.a.1 Inform and Advise Mr. Jones about the dangers of high blood sugar on his entire body, and the importance of controlling blood sugar levels, through an educational group provided at the agency. (BHH SERVICE?)		Any	Once	1 hour	1 day
2.a.2 Collaborate with primary care offices to identify potential practices for Mr. Jones can attend and ones he wants to attend. (BHH SERVICE?)		TCM or CSP	Once	30 mins	2 weeks
2.a.3 Coordinate and submit referral to physician's office. (BHH SERVICE?)		TCM	Once	30 mins	2 weeks
2.a.4 Plan with and coach Mr. Jones to identify the best way for him to remember his appointments with his new doctor. (BHH SERVICE?)		CSP	2xMonth	30 mins	2 mos.
2.a.5 Call Mr. Jones the day before his appointment to ensure he has a plan to remember the appt time and a plan for transportation to the appt. (BHH SERVICE?)		CSP	Once	15 mins	2 mos.

Revised 3/9/15
PLAN START DATE:
Client Rick Jones

Name:

PLAN END DATE:

MPI/Client#: 12345

Program Assignment:

CSP Team

Page 4

Goal 2: Interventions

	BHH Service	Coding
2.a.1	Health Promotion	H227A or H2027/HQ (Psycho-Ed Group)
2.a.2	Comprehensive Care Management or Care Coordination	T116B/T1016/CL (Case Mgmt with Collateral) or TCM03/2023T/CL (TCM with Collateral)
2.a.3	Referral to Community Support Services	TCM03/2023T/CL (TCM with Collateral)
2.a.4	Patient and Family Support	T1016 (Case Mgmt with Client Face to Face)
2.a.5	Patient and Family Support	T116C/T1016/PH (Case Mgmt with Client by Telephone)